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Managed Care Accreditation: Decoding the Acronyms

Randall K. Abbott

JoAnne Gatti-Petito
Sacred Heart University, gatti-petitoj@sacredheart.edu

Health Care

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While their health plan's accreditation status is of increasing importance to employers, they are faced with a bewildering array of accreditation groups and standards.

Managed care has always been full of acronyms. From the beginning, plan sponsors have been challenged to sort out the idiosyncrasies of HMOs, PPOs, POS arrangements, EAPs, PCPs programs and the like. In the past decade, most employers have become comfortable with plan types and delivery models. But, as health care purchasing moves from a focus on plan design and pricing to one of reconciling not only the purchase price but the value of goods, services, and outcomes received, accreditation guidelines and standards have come to the forefront. Indeed, many major purchasers of health care will no longer consider managed care arrangements which lack certain seals of approval.

In the recent Washington Business Group on Health/Watson Wyatt Worldwide survey on "Purchasing Value In Health Care," 79 percent of large employers indicate that they consider accreditation status as an important component when evaluating health plans. But, what are these accreditation standards, where did they come from, and how can they be applied by the pragmatic plan sponsors seeking a "quality" managed care arrangement?

The definition of quality itself continues to be elusive. The National Academy of Science has compiled over 200 definitions of health care quality, ranging from the arcane to the mainstream. Perhaps The Institute of Medicine summed it up best by describing health care quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." Regardless of the definition one chooses, there is no magic formula for determining the level of quality which a health plan will deliver for a covered population.

Despite the historical and emerging quality initiatives underway in the health care marketplace, none of the organizations evaluating managed care arrangements, hospitals, physicians, or other caregivers will guarantee quality of care. Even if they could, how would we define the quality of care ultimately delivered? Would we define it as efficient care? Effective care? Efficacious care? Cost effective results? or Successful outcomes? And, chances are that each constituency in the health care equation would have a different viewpoint. The view of the plan sponsor would certainly be different

RANDALL K. ABBOTT is a Senior Consultant and Regional Practice Leader for the Eastern United States at Watson Wyatt Worldwide. He is based in Little Falls, New Jersey and has over twenty-two years experience in the Employee Benefits, Human Resource Management, and Health Care Consulting fields. JOANNE GATTI-PETITO, RN, MBA is a Senior Consultant and Managed Healthcare Specialist with Watson Wyatt Worldwide in the firm's Stamford, Connecticut office. The contents of this article should be viewed as general in nature. Those seeking specific guidance should consult with a qualified health care advisor.

EXHIBIT 1
Summary of Major Accreditation Organizations

Organization	Focus
National Committee for Quality Assurance (NCQA)	Accreditation of managed care plans and oversight of HEDIS
Joint Commission for the Accreditation of Health Care Organizations (JCAHO)	Accreditation of hospitals, nursing homes, behavioral health facilities, labs and ambulatory care facilities plus health plans
Utilization Review Accreditation Commission (American Accreditation of Health Care Commission) or URAC	Non-occupational and workers compensation utilization review accreditations plus health plan accreditation

than that of the caregiver and might even be different then the perception of the individual patient.

Having said all of this, most experts agree that employer plan sponsors have at least some degree of responsibility for determining not only the degree of access and the current term cost associated with managed care arrangements, but also the managed care organization's ability to deliver care based upon reasonable criteria.

In today's marketplace, a growing number of purchasers utilize the findings of major health plan accreditation organizations as they seek a competent service provider for health care benefits and care delivery. The three most prevalent accreditation organizations are The National Committee for Quality Assurance (NCQA) which accredits managed care organizations and oversees HEDIS, The Health Plan Employer Data and Information Set. A second accrediting organization is The Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) which accredits hospitals, nursing homes, behavioral health care organizations, clinical, laboratory, and ambulatory care facilities. The third is the recently reconstituted Utilization Review Accreditation Commission (URAC) which focuses acutely on standards for utilization review activities in both non-occupational and occupational care management.

While other accreditation organizations exist nationally, regionally, and locally, NCQA, JCAHO, and URAC are perhaps the most widely recognized. Each accrediting organization offers health plan sponsors a wealth of information regarding the structure and process used by health care organizations plus empirical statistical results related to factors which tend to indicate the quality of care being delivered by the health care organization. Exhibit 1 highlights the key areas of focus and activities of these three organizations.

All three organizations have some involvement in the accreditation of health plans, however, NCQA and the HEDIS initiative are probably most closely aligned with the needs of employer health plan sponsors as they assess the potential capabilities and quality indicators of a specific health maintenance organization or point-of-service arrangement. JCAHO offers perhaps the best resource for determining whether the facilities and ancillary providers associated with a managed care arrangement are well managed and applying standards which should assure a reasonable expectation of quality outcomes. URAC is best at utilization review arrangements for both non-occupational and workers compensation care management and is perhaps the soundest indicator when assessing preferred provider organizations (PPOs).

Since all three offer significant opportunities for plan sponsors to benchmark managed care arrangements, the following paragraphs will examine each one of the accreditation programs in detail.

NCQA

NCQA is perhaps the most widely known vehicle for health plan accreditation. Formed in 1979 as a unique partnership between managed care organizations and purchasers of care, NCQA operates with an independent governing structure, independent funding and a particular focus on quality. The Board of Directors consists of representatives from managed care organizations, health service research entities, employers or purchasers of care, unions, individual consumers and physicians. NCQA assesses managed care organizations on five different axes including quality management, utilization management, provider selection, member support, and preventive health services. NCQA has a clearly delineated set of weightings for each of the standards, or sections, addressed by the accreditation process. While comprehensive in nature, NCQA does not address fundamentals like plan leadership, management, or administrative processes. (JCAHO is probably the most comprehensive evaluator of overall plan management, with URAC providing a specific focus on plan management as it relates to network participation and network management.)

Under the NCQA umbrella is the Health Plan Employer Data and Information Set, now in Version 3.0. HEDIS was originally conceived by the HMO group

and a cadre of larger employers. The HEDIS protocol measures five major areas of health care including quality of care, member access and satisfaction, membership and plan utilization, finance, and health plan management activities. While NCQA oversees HEDIS, NCQA accreditation is wholly separate from the HEDIS initiative.

HEDIS is a major step in health plan reporting since it establishes specific definitions and procedures for reporting which are adhered to by all respondents.

Virtually all major managed care organizations in the nation utilize HEDIS reporting to some degree. HEDIS is best as an in-network or HMO-based measurement tool. The five major areas noted above are broken down further into 60 subcategories. First implemented in 1989, HEDIS has become a near-mantra for some employers. However, those closely involved with HEDIS would readily agree that the HEDIS is less than perfect and by its nature provides general indicators rather true quality measures. Nonetheless, HEDIS is widely used and recognized as a fundamental tool in managed care assessment. Despite its shortcomings, it can provide the pragmatic plan sponsor with detailed statistical information regarding plan performance. While the individual scores may or may not be reflective of quality care, the results over several years will certainly indicate the organization's commitment to improving care, especially in those areas where deficiencies have arisen in prior years.

JCAHO

The Joint Commission is the oldest and largest private sector health care accrediting body. In existence since 1951, JCAHO is most widely known for its hospital accreditation program. Accreditation for health care networks has been available since 1994. The Joint Commission's Board of Commissioners includes members from the American College of Physicians, the American College of Surgeons, the American Dental Association, the American Hospital Association, the American Medical Association, six public members, and one nursing representative.

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JCAHO accreditation addresses plan management and leadership, information management, quality management, provider selection and human resource management, member support, health promotion, and disease prevention.

JCAHO has built its standards for health plan accreditations on the foundation of its hospital accreditation program. The standards focus on the management of the health plan and the clinical treatment of the members within the plan. JCAHO, however, does not have a set of standards aggregated into a quality management component. While other assessment areas used by JCAHO address many of the same issues related to quality that NCQA and URAC strive to achieve, the JCAHO focus is less acute. JCAHO accreditation does not include standards for credentialling of institutional providers nor does JCAHO address utilization management in any form.

URAC

Now doing business as the American Accreditation of Health Care Commission, URAC is the newest player into the realm of health plan accreditation. Originally chartered in 1990 as an organization for setting standards for utilization review activities, URAC has since expanded into both worker's compensation accreditation, as well as non-occupational health plan accreditation. The URAC Board of Directors is comprised of representatives from the American Medical Association, the American Hospital Association, the American Nurses Association, the Health Insurance Association of America, as well as employers and labor representatives. To increase its scope within the managed care accreditation arena, URAC has recently acquired the existing accreditation program of The American Accreditation Program, Inc., which is the only independent accreditation for preferred provider organizations (PPOs).[1]

URAC standards are clearly targeted to preferred provider organizations and are the newest and least developed of the three entities. URAC wording, overall, is the most tentative of the three sets of standards. Generally, the URAC language sounds more like suggestions than standards. Scoring guidelines are not available for URAC standards as they are for both JCAHO and NCQA.

While the standards for each of the organizations are similar in nature and none of the standards are truly contradictory, the focus of each is quite different. JCAHO has unquestionably built its health plan accreditation standards from its original beginnings as a hospi-

EXHIBIT 2
Comparison of Accreditation Standards for Major Health Plan Activities

	JCAHO		NCQA		URAC	
Plan Management	Leadership (LD); Management of Information (M)	N/A			Network Participation and Management (NM)	30%
Quality Management	Continuum of Care (CC); Improving Network Performance (PI)	N/A	Quality Management and Improvement (QI); Medical Records (MR)	40% 5%	Network Quality Management (QM)	15%
Utilization Management			Utilization Management (UM)	10%	Network Utilization Management (UM)	30%
Provider Selection	Management of Human Resources (HR)	N/A	Credentialling and Recredentialing (CR)	20%	Network Provider Credentialing (PC)	15%
Member Support	Rights, Responsibilities and Ethics (RI)	N/A	Member's Rights and Responsibilities (MM)	10%	Network Member Participation and Protection (MP)	10%
Health Promotion	Health Promotion and Disease Prevention (PS)	N/A	Preventive Health Services (PH)	15%		

tal accreditation entity. The standards focus on the management of the health plan and the clinical treatment of the members within the plan. NCQA is clearly most focused on quality and a study-based approach to the delivery and evaluation of health care for the population served by the plan. NCQA also has the most specific standards with regard to the delegation of health plan activities to subcontracted entity. URAC accreditation standards are most applicable to preferred provider plans and the URAC emphasis is most clearly on the utilization management activities within those plans. Exhibit 2 compares the accreditation standards of these three entities across six major dimensions. Each dimension is listed with a brief description of what it includes. Where the accreditation organization uses a weighting methodology, the weight for each component is reflected as a percentage.

Beyond these areas of commonality, it is equally important to know where each particular accreditation program has particular strengths or weaknesses.

Of the three, JCAHO is the only one to directly address the ethical philosophy of the health plan for both business and professional conduct. In addition, JCAHO dedicates an entire segment of its standards to organizational leadership. While NCQA and URAC both outline senior management responsibilities with respect to quality management activities, neither provides leadership standards in the areas of network planning, development, contracting and provider services as does JCAHO.

Information Management Systems is an area that is not directly addressed by NCQA in its current standards for accreditation. The prevailing view is that it would be extraordinarily difficult, if not impossible to achieve NCQA accreditation without sophisticated electronic information systems. However, NCQA does not set forth any standards for these systems. URAC addresses health plan needs for automated management information systems. JCAHO has the most comprehensive set of standards to address information management systems. Within JCAHO, there are a total of nine standards that address the collection of information for both internal and external use, the definition and formatting of data elements, transmission of data, data aggregation, and report development.

Unquestionably, NCQA provides the most extensive standards in the area of quality management. NCQA standards for quality management address not only the process, but also the structure of the quality program. NCQA standards are the most prescriptive in the definition of the quality program in the areas that such a program must address. By contrast, JCAHO quality management standards are embedded in its leadership and network performance standards while URAC provides only limited standards within its network quality management section.

Only NCQA provides detailed standards for the specific delivery of preventive services while JCAHO provides limited information and

URAC offers no guidelines in this area. NCQA enumerates specific standards for preventive health, the distribution of those guidelines to practitioners as well as members, and the measurement of the compliance with those standards by various segments of the population served. In particular, NCQA offers guidelines for both childhood and adult immunizations as well as coronary artery disease screening, smoking cessation, cancer screening, prenatal and any other risk factors appropriate to the population group served by the health plan. These standards parallel the area specified by the HEDIS, NCQA health plan measurement initiative.

Experience

At this writing, NCQA has surveyed almost 300 health plans. Of those health plans surveyed 50% have achieved full three year accreditation; 43% have received provisional or one year accreditation and 6% have been denied accreditation. By contrast, URAC had accredited about 21 networks (largely PPOs) as of May 1997. JCAHO has surveyed approximately 20 health plans, all of which have been accredited.

SUMMARY

Accreditation certainly deserves to be a component of the service provider selection process for plan sponsors. Each of the three accreditation organizations provides a broad set of standards to measure health plans. However, each provides a different prospective and focus within those standards. NCQA focuses most heavily on the quality management processes within the health plan while JCAHO focuses on the overall organization and management of the plan. URAC focuses on the Utilization Management activities within the plan.

NCQA accreditation, while widely recognized, may not be the most appropriate accreditation entity for preferred provider organizations because URAC is better positioned to assume that role. When evaluating the accreditation of a health plan it is especially important to consider the type of plan (HMO, POS, or PPO) and the aspects of plan evaluation that are most important to the plan sponsor. Those desiring a heavy emphasis on quality management may want to only consider plans with NCQA accreditation. Those desiring a PPO with tight utilization management may find URAC accreditation to be the best measure of value.

Increasingly, the pragmatic plan sponsor is recognizing that the purchase of health care goods and services for its employee benefit plan cannot be measured solely in access analyses, current term rates, or subjective assessments of perceived health plan quality. More than ever, employers are struggling to move beyond price in an effort to ascribe a true value to the purchase they're making. Provider discounts can be alluring, but if a low price impedes quality of care or ultimately affects the health status of the population in adverse ways, the damage can be immense both in long term cost and overall workforce productivity. After all, what good is a $50 CAT Scan if the results are blurred and the physician isn't qualified to read it? While no accreditation organization can assure quality of care, careful evaluation of accreditation standards, processes and results can help steer decision making in the right direction. ■

Notes:

1. Both NCQA and JCAHO include PPO plans as part of their accreditation audience; however, their standards are designed more directly for HMO-style networks.